

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003283</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY CHARM VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7212 US HWY 31 S</b> <b>INDIANAPOLIS, IN 46227</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00119479 &amp; IN00121941.</p> <p>Complaint IN00119479 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00121941 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: January 16 &amp; 17, 2013</p> <p>Facility number: 003283 Provider number: 003283 AIM number: N/A</p> <p>Survey team: Diana Zgonc RN, - TC</p> <p>Census bed type: Residential: 69 Total: 69</p> <p>Census payor type: Medicaid: 25 Other: 44 Total: 69</p> <p>Sample: 3</p> <p>Country Charm Village was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaints IN00119479 &amp; IN00121941.</p> <p>Quality Review completed on January 18, 2013; by Kimberly Perigo, RN.</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

VOYX11

If continuation sheet 1 of 1